July 13, 2009: HIT-HIE & ARRA Update
Last week was a busy one for Vermont HIT-HIE policy discussions, with two different HIT-related work group meetings, a public meeting for input on Vermont's response to the soon-to-be-funded regional HIT extension center program, and HIT-related discussions at the Health Care Reform Commission.

The week ahead will be equally active, with a VT HIT-HIE Stakeholders meeting on Wednesday (details for that and all public meetings here: http://hcr.vermont.gov/legislation/HCR2009) and in Washington, with the ONC Policy Committee and its Certification/Adoption Workgroup holding a total of three days of meetings Tuesday, Wednesday, and Thursday to discuss Certification Standards and revisit the Meaningful Use discussion.

If they follow past procedure, those ONC meetings will be webcast and also have a toll free numbers to call in to listen. The details on how to dial in are not yet posted on the HHS HealthIT web site, but they should be there soon:
http://healthit.hhs.gov/portal/server.pt?open=512&objID=1269&parentname=CommunityPage&parentid=9&mode=2&in_hi_userid=10741&cached=true (click on Meetings or scroll down to see details.)

HIT & Payment Reform Work Group (7/8/09)
This legislative appointed work group met for the first time last Wednesday. The group is co-chaired by Rep. Anne O'Brien and Senator Bill Carris. Much of the meeting was spent discussing the scope and scale of the work group's charge, and it was quickly agreed that while some elements of the ambitious agenda provided in legislation might not be fully accomplished by the statutory deadline for a report on August 31, 2009, there are nonetheless significant opportunities to chart a course for a statewide initiative that could ultimately provide for comprehensive electronic adjudication of health care claims. The chairs were clear that their objective is to produce a document that will point to something significant in terms of "opportunities for using health information technology to achieve health care payment reform." Because of the vagaries of ARRA related funding (see previous Updates and HIT at HCRC below), the work group will not be able to develop an actual grant proposal in this time frame, but its recommendations could constitute one of the chapters of the updated State HIT Plan and form the basis for a more comprehensive implementation proposal and plan. The work group plans to create a road map for how to move ahead in this area.

It was agreed that while it might be phased in over time, the goal of the work group is a statewide initiative that would ultimately provide for comprehensive electronic adjudication of health care claims. An immediate step to inform the group's understanding will be to review the current state of these (primarily batch) transactions to see what is required to achieve the vision of a real time (or close to real time) transactional system. The model that was offered was the type of system some dentists and dental insurers have in place, where the dentist and insured patient can see what is and isn't covered by their insurance, and thus, what a consumer would owe.

There needs to be additional discussion about how this could be achieved, but the work of the next meeting, as well as some interim research, will be to frame the questions to be answered in the short, medium, and long term related to this project. Work group participants agreed that improving the electronic exchange of health care financial transactions complements our work on the exchange of clinical data, and that this could fit into the overall framework of Vermont's expanded, scaled up health care reform implementation, given additional federal resources. But like all the rest of our HIT topics: details to follow. (Detailed Meeting Minutes & Action Items will be posted to the HRC web site prior to the next meeting, scheduled for 7/22, starting at 10:30.)

HIT & Higher Education Work Group (7/9/09)
The work group spent a productive hour in advance of the Regional Extension Center discussion starting to focus on the specific work to be accomplished. As in previous discussion, there was wide agreement that getting this training capacity for the HIT work force up and operational as quickly as possible is essential. Three separate areas (and volunteers to lead them!) were identified: (Training Needs and Types, Education Resources in the state, and Demand/Scale of Need).

At the next meeting (scheduled for 1:30 p.m. on Wednesday, August 12, in advance of the Stakeholders meeting) we will focus on:
1. What are the roles and skills required in the HIT work force?
2. What competencies do they need training in? (There will obviously be multiple levels of competencies for different job needs.)
3. What resources (higher education programs and institutions) are ready now or will soon be ready to provide this training? What is their content focus? How does that match up to the needs identified in 1. and 2.?
4. What is the potential scale of work force need, based on projected needs per hospital, per physician practice, and for other health providers?

Feedback from Vermonters on the federal Regional HIT Extension Center Program (7/9/09)
Although the only published information about the Extension Center program is in the HITECH Act itself (Sec. 3012 grants) and in a Federal Register notice, indications are that ONC plans to release guidance for competitive funding of Regional Extension Centers later this summer or in early fall. While we do not yet know the definition of a "region" for the program, many observers suggest that there will at least be one Extension Center per state, possibly even sub-state regional centers, although there are also those who believe there will be multi-state regions. In any event, whether as a sub-contractor/partner of a multi-state Regional Extension Center or single state grantee, we expect to see a Vermont Extension Center Program.

Last Thursday's meeting was to gather public input about how we can best accomplish the program's goals:
1. Encourage adoption of electronic health records by clinicians and hospitals,
2. Assist clinicians and hospitals to become meaningful users of electronic health records, and
3. Increase the probability that adopters of electronic health record systems will become meaningful users of the technology.
According to the Notice, the core purpose of the Regional Centers is to "furnish direct, individualized, and (as needed) on-site assistance to individual providers, and they are to serve both new adopters of EHR and those requiring a "reboot" or reimplementation of their system.

After discussion, the group agreed that VITL is the likely logical home for our HIT Extension Center program. However, it was noted that this would constitute "a different line of business" for VITL, beyond its current core functions, which are operating Vermont's statewide HIE and providing adoption and implementation assistance for a defined list of EHR products. The group articulated a need for a clear "firewall" between those functions and the Extension Center, since it needs to be scrupulously “platform agnostic,” supporting all certified approaches to EHR. Dr. David Cochran, VITL's new President/CEO agreed with the importance of that distinction. It was also noted that although the federal program goals are focused on clinicians and hospitals, because our Vermont goals include extending health information exchange to long term care, home health, mental health, behavioral health, and substance abuse services providers, the center's support should extend to them as well.

It was further agreed that the next step would be to formally constitute a Regional HIT Extension Center Advisory Council, consisting of representatives from appropriate stakeholder

organizations, including professional associations, higher education, and other interested parties consistent with those listed in the Notice. Having such a body constituted and in-place prior to the release of application guidance for grant funding will demonstrate our readiness and commitment. Accordingly, I will be soliciting Advisory Council members directly and hope to have it constituted by early August.

HIT at HCRC

I had the opportunity to update the Health Care Reform Commission (HCRC) on HIT last week, specifically focusing on funding opportunities. Readers of these email updates are aware of the current dearth of detail, and I had no additional information for the Commission. I explained our strategy for approaching the feds with a comprehensive new state HIT plan that highlights Vermont's HIT-embedded health care reform strategies and their alignment with national policy priorities. We anticipate putting together a comprehensive proposal that could take maximum advantage of both CMS and ONC HIT-HIE funding streams, as well as seeking additional funding through the Comparative Effectiveness Research and HIT discretionary grants issued through the HHS Secretary's Office. Such funding might enable us to dramatically enhance resources available to support the Blueprint for Health expansion to more communities and populations, as well as link providers with networks of community care team partners with secure, real-time exchange of health information.

Many of the health policy goals articulated in the ARRA (American Recovery and Reinvestment Act) -- ranging from using HIT to improve health outcomes to delivery system strategies to improve management of populations with multiple chronic conditions -- align with our overall approach to health care reform, making Vermont all the more likely to gain preference for funding in some of these federal initiatives. As I suggested in my testimony, this is the moment and these are the national opportunities that Vermont has been waiting to seize since passing and beginning to implement health care reform here in Vermont.

A question was raised by Rep. Topper McFaun: "Does the FAHC PRISM Regional Model undermine VITL and State Level HIE?" This followed a presentation on the prospective Fletcher Allen Health Care (FAHC) regional deployment of its EHR. The question was whether this model was in conflict with the role of VITL as the single, state-wide Health Information Exchange infrastructure. Because of the many layers of system connectivity, the confusion is understandable.

That said, it is important to clarify that what FAHC is proposing (having various Vermont hospitals and/or physician practices utilize their EPIC EHR) is wholly consistent with state HIT planning and policy. FAHC is offering what is called "a hosted solution," meaning that instead of a doctor's practice, Critical Access Hospital, or home health agency installing and maintaining its own servers on which the data reside, FAHC is partitioning its servers in a centralized location. This provides an economy of scale that lowers the operating cost and provides the opportunity for shared "help desk" staff, etc.

Many commercial vendors offer hosted EHR solutions. What is different about PRISM Regional is that the vendor is a health care system offering to effectively "re-sell" a segmented part of its EHR to organizations outside of the system. Nonetheless, patients whose records are part of the PRISM EHR will be able to be exchange data with other non-PRISM providers through the VITL HIE. What FAHC is offering is no different than what some physician practices in Vermont already do, with a shared server hosting EHRs for multiple, separately owned practices. Those hosted servers live both inside and beyond Vermont's borders.

By design, there is no "central data base" of all the state's health information at VITL. There is a central exchange, a transfer station so to speak, between many, many networks of data bases

holding health information across (and beyond) the state. Technically, there are data bases that help operate the exchange (to correctly identify and match patient and provider records, for instance), but the EHR data base, the patient health record, "resides" either at a practice or its host's site. One advantage to hosted sites' connections to VITL is that they reduce the number of interfaces and so lower both the initial installation cost and the cost of changes required when systems are upgraded. The VITL connectivity agreements with providers ensure that all data exchange meets the standards and specifications of our state HIE policy, at the core of which is the goal of universal exchange across all providers and organizations (as opted into and permitted by the patient). In other words, we have multiple processes in place to ensure legislative policy intent is fully met when it comes to HIE, and given the imperative to increase the pace of EHR deployment, having multiple partners across the state working to achieve those goals will benefit us all.

This Week's Activities

The Markle Foundation, the Center for American Progress, and the Engelberg Center at the Brookings Institution are sponsoring a forum Wednesday, 7/15: *Aligning Health IT and Health Care Reform: Achieving an Information-Driven Health Care System* in which I will be participating to tell "the Vermont HCR-HIT story." (It will be streamed live, starting at 9 on Wednesday, here: http://www.americanprogress.org/events/2009/07/healthIT) Thanks to the opportunity to participate in this forum, I will also be attending the HIT Policy Committee Meeting on Thursday and will provide a first hand report on the day's discussion of the evolving discussion of Meaningful Use criteria later in the week. Our Vermont HIT-HIE Stakeholders meeting will be held Wednesday afternoon. AHS CIO Margaret Ciechanowicz will host the meeting in person, and I will call in. Again, the details for this and all our meetings are here: http://hcr.vermont.gov/legislation/HCR2009.

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